

June 27, 2016

VIA REGULATIONS.GOV

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

The American Association of Hip and Knee Surgeons (“AAHKS”) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) on its proposed rule implementing the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) through Merit-Based Incentive Payment System (“MIPS”) and Alternative Payment Models (“APMs”) (hereinafter referred to as “MACRA proposed rule”).

AAHKS is the foremost national specialty organization of more than 2,800 physicians with expertise in total joint arthroplasty (“TJA”) procedures. Many of our members conduct research in this area and are experts on the evidence based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS offers these comments in anticipation of continued close collaboration with CMS to ensure Medicare payment reforms benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of MACRA proposed rule:

MERIT-BASED INCENTIVE PAYMENT SYSTEM

I. Quality Performance Category

a. Decreasing Required Quality Measures – Sec. II.E.5.b.(1)(a)

CMS proposes to decrease the nine quality measures required under the 2016 PQRS requirement to six quality measures in 2017. CMS also proposes to no longer require reporting across multiple National Quality Strategy (“NQS”) domains.

AAHKS Comment: We support this proposed change to the number of quality measures required to be reported by physicians. As MIPS expands the factors that are reported and considered under the new Quality Payment Program (“QPP”), it is appropriate that reporting under some categories be reduced to account for the total time and effort necessary for physicians to comply with MACRA. Given the changes that will occur with implementation of MACRA, particularly in the first few years, we recommend that reporting obligations should be maintained at the minimum volume necessary.

From our experience to date in 2016, a higher number of required measures can occasionally pose problems for specialists for whom there are limited measures. While AAHKS has been actively involved in measure development and maintains five of the 14 measures currently available in the Orthopedic Surgery Category under the Physician Quality Reporting System (“PQRS”), even these 14 measures are limited in scope across measure type and domain. Decreasing the reporting burden, and ensuring that the remaining measures are the most meaningful to beneficiaries and those who treat them, is an encouraging step.

b. Increasing Requirements for Outcome Measures – Sec. II.E.5.b.(1)(a)

CMS states that outcome measures are more valuable than clinical process measures and are instrumental to improving the quality of care patients receive. CMS plans to “increase the requirements for reporting outcome measures over the next several years through future rulemaking, as more outcome measures become available.”

AAHKS Comment: We agree with the value to the Medicare program of increasing required reporting of outcome measures. Such an increase, however, is predicated on the existence of sufficient outcome measures for surgical procedures. While measures currently exist under the PQRS and electronic Clinical Quality Measures (“eCQMs”) (PQRS 376 and 376) that track the percentage of TJA patients who have completed baseline and follow-up functional status assessments, these are process measures. We note that all other measures available in the “Orthopedic Surgery” category of Table E are process measures. In fact, extensive work between CMS and the national orthopaedic specialty associations is needed to develop applicable outcome measures.

Outcome measures for TJA procedures can be based upon the functional status assessments currently used by surgeons. The timeframes currently applied under the measures are insufficient to assess the clinical outcome of the procedures, such as a post-operative timeframe for evaluation of 60 to 180 days. The most clinically appropriate time frame for a post-operative functional assessment should be at least from 180 days to one year following surgery, as TJA patients do not reach 90 percent functionality until at least 180 days after surgery. Full functionality is most likely to occur at one year following surgery.

Additionally, while the number of functional assessment tools allowable under existing measures has increased, the list must be expanded further to capture those most commonly available to orthopaedic surgeons.

We believe there is interest among measure developers to address this next level of TJA measures. The American Joint Replacement Registry and other sources may be appropriate partners to assist in the development of outcome measures. Patient-reported outcome measures may serve as a starting point and inform the development of outcome measures, but we would point CMS to discussions among payers and providers in the Health Care Payment - Learning and Action Network (“HCP-LAN”) in which there was agreement that patient-reported outcome measures do not reliably assess the performance of the surgeon or the outcome of the TJA procedure. AAHKS already has demonstrated experience in partnering with national orthopaedic specialty associations, CMS, other payers, and measure developers on the adoption of other consensus outcome measures, and we look forward to continuing such relationships as MACRA unfolds.

c. Risk Adjustment for Socioeconomic Status – Sec. II.E.5.b.(1)(a)

Regarding quality performance measures, CMS notes it will “closely examine” the results of current analysis conducted by the HHS Assistant Secretary for Planning and Evaluation (“ASPE”) and the National Quality Forum (“NQF”) on the issue of risk adjustment for socioeconomic status and “incorporate them as feasible” in future rulemaking.

AAHKS Comment: We eagerly await CMS action to improve risk adjustment based on socioeconomic factors following completion of the ASPE and NQF analysis. Providers of all types have become more aware of the impact of socioeconomic factors on clinical outcomes. CMS considers the ASPE and NQF reports important enough to have indicated they will play a role in future rulemaking under the Inpatient Prospective Payment System and rate announcements for the Medicare Advantage program. We are grateful for CMS’ appropriate focus on the importance of accurate risk adjustment. We hope that CMS will extend this risk adjustment emphasis into the one program most significantly missing it to date: the Comprehensive Care for Joint Replacement (“CJR”) model.

In the inpatient setting, AAHKS members have historically been assessed on readmission, re-operations, cost, and length-of-stay, but these measures often inadequately account for the wide variation among patients and therefore lose their comparative value. Health status, stage of disease, genetic factors, local demographic and socioeconomic factors significantly impact the quality and outcomes of surgeries performed. Without properly adjusting for all of the factors that impact quality, physicians will be subject to payment adjustments that are reflective of the patient population and not reflective of the actual quality of care provided. We are concerned that MIPS will fail to incentivize better care if physicians find the measurement of quality dependent on factors outside the control of these physicians, and may in fact disincentivize care for those who are most in need.

d. Use of All-Payer Data – Sec. II.E.5.b.(1)(c)

In multiple parts of the proposed rule, CMS stresses its desire to enhance the use of all-payer data within quality reporting. Specifically, CMS indicates a future desire to use all-payer data for the Consumer Assessment of Healthcare Providers and Systems (“CAHPS”) for MIPS Survey, as well as for all quality measures data submitted via Qualified Clinical Data Registry (“QCDR”), qualified registry and electronic health records (“EHRs”).

AAHKS Comment: We question the decision to include all-payer data in a quality program used specifically for measuring performance related to Medicare beneficiaries. While we acknowledge that all-payer data may be valuable in some respects, we believe that CMS is going beyond the boundaries necessary or appropriate for determining reimbursement under the QPP.

Different payers stress different approaches to care, and lumping private payer data in with Medicare data does not recognize the differences in approaches used by public and private payers. The initial performance periods for MIPS should focus on implementing only those provisions required by the law and should avoid using Congressional reforms as a back door for creating new reporting requirements. Eventually, all parties may come to agree on the utility of all-payer data, particularly through the ongoing work of the HCP-LAN. Until that point, CMS should not expand quality measure reporting populations beyond current requirements.

Furthermore, we ask CMS to explain its source of authority under MACRA for incorporating commercial payer information into the QPP.

II. Resource Use Performance Category

a. Value Modifier Cost Measures Proposed for the MIPS Resource Use Performance Category – Sec. II.E.5.e.(3)(a)

The resource use performance category will be assessed using measures based on administrative Medicare claims data with no additional data submissions required. MIPS eligible clinicians and groups, therefore, would be assessed based on resource use for Medicare patients only and only for patients that are attributed to them. CMS proposes to use the same methodologies for payment standardization, and *risk adjustment* for these measures for the resource use performance category as are defined for the Physician Value-Based Payment Modifier (“VM”). Those methodologies are described in the 2012 Physician Fee Schedule Final Rule where CMS indicates that it uses the HCC model, which assigns **prior year** ICD-9-CM diagnosis codes to 70 high cost clinical conditions to capture medical condition risk and also incorporate age, gender, and Medicaid eligibility status.

AAHKS Comment - CMS should clarify whether, under the proposed VM model, resource use by a particular physician or group is risk adjusted based on **all HCC codes attributed to the patient in the prior year**, or only those HCC codes entered by the particular physician subject to the

resource use measure. In the case of a surgeon, many may not have had a patient-provider relationship in the prior year and therefore would not themselves have recorded HCC codes in the patient record in the prior year. The risk adjustment should be based on any and all HCC codes attributed to the patient in the prior year.

CMS should also clarify that collection and attribution of HCC codes is not limited to Part B claims. As inpatient hospital payments have been by risk adjusted for several decades under Medicare Severity-Diagnosis Related Groups (“MS-DRGs”), hospitals are much more effective at HCC coding. Hospitals have a track record of capturing more diagnoses through Part A claims than are done through Part B claims.

Furthermore, development of risk adjustment methods must be done with close consideration of minimizing additional data collection steps for providers. Many important risk factors for adverse patient outcomes currently are either not measurable using available data (e.g., preoperative functional status) or are not consistently reported (e.g., obesity).

b. Episode-Based Measures Proposed for the MIPS Resource Use Performance Category – Sec. II.E.5.e.(3)(b)

CMS proposes to collect and calculate several episode-based measures for inclusion in the resource use performance category, including measures for total hip arthroplasty (“THA”) and total knee arthroplasty (“TKA”) episodes. CMS proposes to use episode-based measures previously developed and used under the Supplemental Quality and Resource Use Report (“sQRUR”). Through the sQRUR, these measures are issued as part of the Physician Feedback Program to clinicians and groups to allow them to evaluate their own resource use on procedures that are costly and prevalent in the Medicare program. These measures have never before been used for payment adjustments.

CMS offers two sets of episode-based resource measures developed recently with alternative episode triggers (Tables 4 and 5) and solicits feedback on which are appropriate to include for payment adjustment in the final rule. The measures in Table 4 were developed with an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, accommodating both chronic and acute procedure episodes. In this case the two Table 4 measures for “Hip Replacement or Repair” and “Knee Arthroplasty” are each triggered by a patient claim with any of the interventions assigned as trigger codes, including designated ICD, CPT, and HCPCS codes.

The measures in Table 5 were developed to supplement existing QRURs and represent only acute conditions, measuring services independently, regardless of other episodes a patient may be experiencing. For these measures of “Hip Replacement or Repair” and “Knee Arthroplasty”, the episodes are triggered by the presence of an assigned CPT/HCPCS code on a claim where that code is the highest cost service for a patient on a given day.

AAHKS Comment: AAHKS opposes the use of the THA and TKA measure numbers 25 and 26 found in Table 4, known also as “Method A” at this time. While CMS and its contractors have evaluated measures under Method A, they have never before been calculated for physicians and certainly never applied for payment adjustments. We are concerned that it would be presumptuous of CMS to use these measures in the initial years, given that CMS is still soliciting feedback on the descriptions of the episodes through August 2016.

The THA and TKA measures 6 and 7 found in Table 5, known also as “Method B,” would be preferable because practices have at least received assessments under these measures previously through the sQRUR. Many practices will therefore have a baseline understanding of their performance level. AAHKS will be responding in August 2016 to both CMS requests for comments on the Supplemental Episode Groups and the associated Patient Relationship Categories and Codes.

Finally we note that, at section II.E.5.e.(4), CMS intends to consider adding Medicare Part D drug costs to the resource use calculation in future rulemaking. We would note that it is presently unclear if the technical capacity exists to match Part D claims to individual physician prescriptions. Furthermore, if the capacity does exist, CMS must incorporate a means to ensure that Part D costs attribute to a physician are limited to the prescriptions and expenditures within the control of the physician. For instance, Part D costs included in an episode based resource measure for TJA should exclude costs unrelated to the TJA procedure.

III. Clinical Practice Improvement Activity Category

a. CPIA Submission Criteria – Sec. II.E.5.f.(3)(c)

CMS lays out CPIA submission criteria under which the highest potential score of 100 percent for three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or some combination of high and medium-weighted CPIAs to achieve a total of 60 points. CMS proposes that under the CPIA performance category, a clinician or group that is participating in an APM will receive 50 percent of the total CPIA score (30 points) solely through their APM participation.

AAHKS Comment: We endorse the proposal to grant an automatic score of 30 points for participating in an APM as we interpret that this would include participation in the CJR model. While we believe that CJR participation will ultimately be considered by CMS to be participation in an Advanced APM, it is appropriate that physicians be rewarded for participation in any of the many APMs that significantly advance value-based payments.

b. CPIA Inventory – Sec. II.E.5.f.(7)

The MACRA statute requires CMS to create an inventory of CPIAs that will qualify for the CPIA performance category. CMS’ stated intent is to create a broad list of activities that can be used

by multiple practice types and that may lend themselves to being measurement for improvement in future years. CMS requests comments on the inventory offered under Table H.

AAHKS Comment: We thank CMS for proposing 14 CPIAs related to reporting to and use of a QCDR. We believe that QCDRs, such as the American Joint Replacement registry (“AJRR”), are an essential tool in care improvement. Many AAHKS members participate in the AJRR which leads to enhanced patient experience and benchmark performance; reduction in complications and revision rates; and post-market surveillance of implants. Because such registries are already performing all the activities intended to be advanced through MACRA, we believe that all CPIAs related to QCDR use should be granted a “high” weighting.

IV. Advancing Care Information Performance Category – Method Data Submission – Sec. II.E.5.g.(5)(b)

MACRA consolidates the existing meaningful use EHR incentive program into a new Advancing Care Information (“ACI”) category. CMS implements ACI by reducing the number of measures and introducing greater flexibility in the measure assessment. This ACI process includes new requirements for entities that serve as intermediaries for submission to CMS of data under MIPS. CMS admits that “some Health IT vendors, QCDRs and qualified registries may not be able to conduct this type of data submission for the 2017 performance period given that the development efforts associated with this data submission capability [sic].”

AAHKS Comment: We agree that many EHR vendors will be hard pressed to successfully update products to comply with final MIPS standards that will not be finalized by CMS until the Fall. By nevertheless assessing providers on the ACI category for performance year 2017 many providers will be penalized. Many clinicians and their groups and institutions have long-standing relationships with vendors who understand the needs of their practice. We prefer that providers not be forced to choose between having a reduced score in the ACI category or having to scramble in the final weeks of 2016 to determine which vendors have compliant and operational reporting systems. For the purposes of the ACI category, CMS should commence the 2017 performance period in the second half of the year to allow for vendors to complete and test fully compliant products in response to the final MACRA rule.

ALTERNATIVE PAYMENT MODELS

Congress intended with passage of MACRA to not only reduce the cost of care but revolutionize the way in which care is provided. Participation in APMs is a central element in ensuring that the latter goal is met. Generally, we believe that CMS should strive to ensure that physicians of all specialties, practice sizes, and geographic settings have access to APMs. Participation in Advanced APMs not only allows physicians to strive for improved efficiency and practice, but also includes financial incentives that avoid the potential penalties associated with MIPS. Given the importance of APM participation to both the practice and reimbursement of Medicare physicians, access to Advanced APMs should be attainable for all physicians.

The policy principles stated by CMS in the proposed rule provide valuable insight into how MACRA provisions related to APMs will be administered. We agree with CMS that an expanding portfolio allowing for broad participation is critical, while also noting that the incentives associated with Advanced APMs mean that the program is intended to be challenging and rigorous. However, we stress the importance of providing APM Entities and Qualifying APM Participants (“QPs”) with attainable goals that do not deter potential participants. The limited number of Advanced APMs available for the 2017 performance year and the dramatic difference in participation for MIPS and Advanced APMs is indicative of the need to expand the scope of APMs in future performance years.

I. Identification of Advanced APMs – Sec. II.F.4

CMS has defined criteria for determining whether the design of an APM qualifies as an “Advanced APM” for purposes of a participating clinician’s eligibility for a 5 percent annual lump sum bonus payment and exclusion from the MIPS Program. Specifically, an APM must require participants to use certified electronic health record technology (“CEHRT”), provide for payment for covered professional services based on quality measures that are comparable to those in the quality performance category under MIPS, and either require that the participating APM Entities bear more than nominal risk for financial losses under the APM or be a Medical Home Model.

In the proposed rule, CMS identifies six current models and demonstration programs being tested through the Center for Medicare and Medicaid Innovation (“CMMI”) that would be considered Advanced APMs under the established criteria. However, CMS does not include the CJR model in the list of Advanced APMs.

AAHKS Comment: We urge CMS to designate the CJR model as an Advanced APM, and we appreciate that CMS specifically seeks comments on how the CJR model could be redesigned to make it an Advanced APM. We have a number of suggestions for redesigning the CJR model in a manner that would allow it to qualify as an Advanced APM.

First, the CJR model does not allow for physicians to manage care provided under the bundled payment. CMS currently limits the CJR episode “initiators” and “conveners” to hospitals, even though 60 percent of the 90-day episode of care occurs outside of a hospital. CMS should allow physicians with requisite qualifications to participate in CJR as episode initiators and conveners. Accordingly, the two-sided financial risk that currently only applies to hospitals (starting in the second year of the CJR model) could also be applied to physicians who participate in CJR as episode initiators and conveners. In addition, for physicians who serve as collaborators with hospitals in the CJR model, CMS should allow those physicians to be identified as CJR model participants and two-sided risk arrangements between such hospitals and physicians should be deemed as the acceptance of “more than nominal” financial risk.

Second, the episodes of care included in the CJR model should be based on a provider's ability to engineer change in the way care is delivered to the patient. Accordingly, the episodes of care included in the CJR model should be limited to elective TJA due to osteoarthritis. Elective procedures are a comparatively controlled clinical event, more subject to provider influence and care, unlike fracture cases that are currently included in the CJR model.

Third, quality measures reported under the CJR model should be expanded to include physician-reported measures, rather than the two facility-based measures that are currently included in the CJR model. The two measures currently included in the CJR model are the hospital-level risk standardized complication rate following elective primary THA and/or TKA measure and the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey measure. For example, there is a set of orthopedic surgery measures specific to THA and TKA that should be incorporated into the CJR model. Further, as discussed above, CMS should develop TJA outcome measures with a longer timeframe than 3-6 months. Such outcome measures should be incorporated into the CJR model as well.

Fourth, CMS needs to incorporate a risk and severity adjustment method into the CJR model, so that hospitals and physicians treating high risk patients are rewarded when they achieve the same quality as those hospitals taking on only low risk patients. For example, AAHKS has found that compared to primary THA for osteoarthritis, conversion THA is associated with significantly more complications, a longer length of stay, and more likely discharge to continued inpatient care, implying greater resource utilization for these patients versus primary THA. Therefore, conversion THA appears to be one procedure for which risk-adjustment is appropriate.

Fifth, to ensure that the goals related to use of CEHRT are met, a requirement could be added to the CJR model that at least 50 percent of participants do "end-to-end" reporting of quality metrics through the use of an EHR that exports data to a QCDR.

Finally, CMS should make the CJR model voluntary so that all hospitals and surgeons who would like to participate are able to do so. Alternatively, surgeons who practice at hospitals subject to the CJR model may want to participate in other Advanced APMs, and should have the flexibility to do so. Initial evidence reported from CJR participating hospitals suggests that 60 percent of them are expected to lose money through the CJR due to far lower than anticipated target prices. The flexibility requested is necessary to ensure a level playing field of APMs for providers and to encourage surgeons to be co-conveners of risk.

II. Use of CEHRT Requirements – Sec. II.F.4.b.(1)

For the 2017 performance year, CMS proposes to require that at least 50 percent of eligible clinicians participating in an Advanced APM must use CEHRT to document care and communicate with patients and other health care professionals. This threshold increases to 75 percent in the 2018 performance year and beyond. In implementing this requirement for an Advanced APM to use CEHRT, CMS solicits comments on issues including whether the criteria

for Advanced APM technology should be the same for all payers and whether a 50 percent threshold of eligible APM participants is acceptable.

AAHKS Comment: We believe that linking EHR requirements to the particular payer is the most reasonable way of approaching this standard. In practice, the Medicare standard will likely serve as a floor beyond which third-party payers can proceed if they so desire. Much of an APM's purpose is facilitated by common technology and we believe standards unique to the particular Advanced APM are appropriate in many circumstances. Additionally, the requirement that 50 percent of Advanced APM participants use CEHRT appears reasonable for the first performance period.

However, we do not believe that it is appropriate or necessary to increase minimum CEHRT levels sharply between the first and second performance years. The increase of the threshold from 50 to 75 percent should be gradually phased in over a period of years to allow greater transition time and the opportunity for upgrades. Data provided by CMS indicates that very few eligible clinicians will qualify for Advanced APM participation in the 2017 performance year, meaning that a significant portion of Advanced APMs cannot take advantage of the 50 percent transition year because it only lasts for one performance period. New Advanced APMs should be given time to satisfy the CEHRT threshold while also trying to complete all of the tasks required for creation of a new Advanced APM. This is best accomplished by either phasing in the 75 percent level or making an exception for new Advanced APMs.

III. Financial Risk Requirements – Sec. II.F.4.b.(3)

In the proposed rule, CMS considered, but rejected, the concept that the required assumption of financial risk by Advanced APMs can arise from an APM's "business risks" associated with the size of the financial investments made by an APM, in terms of time and money, to meet the conditions to be an Advanced APM. CMS felt these business risks would vary too widely and might be difficult to quantify, leaving it uncertain whether a particular APM has, or has not, assumed more than a "nominal" amount of financial risk. CMS seeks comments on how to craft objective financial risk criteria that would define financial risk for monetary losses differently than its proposal.

AAHKS Comment: We urge CMS to reconsider this proposal, and to include the true variety of financial risks faced by physicians when establishing alternative payment innovations: initially establishing infrastructure for data analysis and procedures for coordinating care and sharing information; participating in a clinical data registry; jointly developing treatment plans; ongoing costs for new employees such as care managers; and foregone revenue from billable services that are reduced under an APM due to the use of appropriateness guidelines and efforts to reduce emergency department visits and hospitalizations.

If these practices do not lead to financial savings, practices are at risk for losses even if the practice is not required to make a payment to CMS. The financial risk to the practice or APM Entity is that the revenue from the APM may not cover the costs of participating in it. The

practice could be saving money for Medicare by reducing hospital admissions and expensive tests and procedures, but still be losing money for the practice. The definition of more than nominal financial risk should not be based on the relative gain or loss to the Medicare Trust Fund, but on how much the physician practice or APM Entity gains or loses.

IV. Definition of Medical Home Model – Sec. II.F.3

Medical Home Models that have been expanded under CMMI’s demonstration expansion authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While Medical Home Models have not yet been expanded through CMMI, the proposed rule lays out criteria for Medical Home Models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

AAHKS Comment: The definition for a medical home cited by CMS appears to largely preclude specialty medical homes. The definition notes that the Medical Home Model includes either primary care practices or multispecialty practices that also include primary care physicians and other practitioners offering primary care services. CMS further states a principle that medical homes are intended to focus on primary care, which seems to preclude any medical home that includes primary care but is focused on specialty care. We believe that this definition could eliminate future innovative Medical Home Models that focus on specialty care for complex patients with chronic needs, many of whom rely on their specialty physician as a de facto provider of primary care. However, we do appreciate that CMS provided for elements of medical homes such as continuity of care, coordination of chronic and preventive care, and coordination across the medical neighborhood. These elements will assist multispecialty practices when seeking to qualify as an Advanced APM.

V. Determination of Qualifying APM Participants – Sec. II.F.5

CMS notes in the proposed rule that a clinician’s eligibility as a QP is at the group level and based on all eligible clinicians participating in an Advanced APM.

AAHKS Comment: We believe that this approach is the best way of ensuring that APM requirements are met without instituting a burdensome new reporting requirement. Eligibility for an Advanced APM is appropriately based on the APM itself rather than satisfaction of an additional set of criteria.

There are concerns, though, surrounding the requirement that an eligible clinician be listed as a participant on December 31 of the QP performance period in order to qualify. This requirement essentially eliminates the ability of any eligible clinician to participate in an Advanced APM – or potentially a collection of Advanced APMs – on a partial year basis. CMS also left open many of the specific requirements pertaining to participant lists and the practical steps associated with ensuring that eligible clinicians are listed.

Further, we do support the decision to apply QP status to an eligible clinician’s National Provider Identifier (“NPI”) rather than limiting status to the Taxpayer Identification Number (“TIN”) affiliated with the Advanced APM. CMS notes that this policy ensures that providers do not inadvertently qualify for MIPS based on one segment of their practice when, in reality, they qualified under an Advanced APM based on another practice area. This is an important step toward ensuring that participation in an Advanced APM satisfies all requirements to be excluded from MIPS.

VI. Combination All-Payer and Medicare Payment Threshold Option – Sec. II.F.7

For 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and APMs with other payers (“Other Payer Advanced APMs”), such as private insurers, state Medicaid programs, and Medicare Advantage plans. An Other Payer Advanced APM must meet criteria similar to those for Advanced APMs. This All-Payer Combination Option allows a clinician to become a QP based on the amount of Medicare Part B covered services furnished through a Medicare Advanced APM plus the amount of services furnished through an Other Payer Advanced APM.

AAHKS Comment: Allowing for participation in Other Payer Advanced APMs to count towards QP status is likely to encourage broader participation in APMs. More and more payers are committing to moving their medical spending to value-based contracts, including payers who are committed to APM adoption through implementation of the recommendations developed by the HCP-LAN.

While CMS indicates that APMs through other payers will be determined to be Other Payer Advanced APMs based on similar criteria to that established for Advanced APMs under Medicare, we urge CMS to clearly define the process for determining if another payer’s APM qualifies as an Other Payer APM. This could include the adoption of deeming standards for such APMs (e.g., for APMs that have been developed through HCP-LAN recommendations).

Further, CMS proposes that APM Entities and eligible clinicians must submit data on payment and patient numbers for each payer from whom the eligible clinician group or individual has received payments. Specifically, CMS states that the following information must be submitted: (1) the payment amounts and/or number of patients furnished any service through each Other Payer Advanced APM for each payer; and (2) the sum of their total payment amounts and/or number of patients furnished any service from each payer. In addition, CMS will ask each payer to attest to the accuracy of all submitted information including the reported payment and patient data. We urge CMS to adopt a data submission process that minimizes the burden on clinicians, who may not have this information readily available, and the payers who have to attest that the data is accurate.

VII. Participation in Multiple Advanced APMs – Sec. II.F.6.c.(4)

CMS includes an exception to the QP determination process at the group level for individual eligible clinicians who are identified as part of multiple Advanced APM Entities, none of which meet the QP threshold based on payment or patient count.

AAHKS Comment: We appreciate that CMS recognizes that physicians, including surgeons, could be participating in multiple arrangements that qualify as Advanced APMs, and that participation in multiple Advanced APMs could count towards the payment and patient count thresholds established for QP-status under an Advanced APM. Surgeons are increasingly likely to be participating in bundled care arrangements as well as accountable care organizations or collaborative care networks. However, given the high threshold for an APM to qualify as an Advanced APM, it is unclear how many of our members would currently meet the QP standards for participation in one Advanced APM, let alone multiple Advanced APMs. Therefore, in addition to the primary care-focused Advanced APMs discussed in the proposed rule, we urge CMS to adopt new models that focus on physician specialists and surgeons.

VIII. Physician-Focused Payment Models

a. Proposed Criteria – Sec. II.F.10.c

The proposed rule establishes the Physician-Focused Payment Technical Advisory Committee (“PTAC”) to review and assess additional physician-focused payment models (“PFPMs”) suggested by stakeholders for possible inclusion in the QPP. CMS is required to establish PFPM criteria to be used by the PTAC to make comments and recommendations on proposed PFPMs to CMS.

AAHKS Comment: We understand that PTAC has the authority to prioritize specific patient groups or specialties. Practically speaking, it is reasonable to assume that PTAC will prioritize certain areas due to gaps in existing APMs. However, we urge CMS to clarify that PTAC is able to set priorities but should not exercise this authority by blocking access for specialty providers. Instead, proposals should be expected to focus on physicians who do not have the opportunity to participate in other APMs due to the specialty’s lack of inclusion in CMS APM pilot programs.

We would like to stress the importance of providing stakeholders with an accessible mechanism for approval of PFPMs.

Further, we have concerns over ambiguities related to the manner in which CMS will consider PTAC recommendations for new APMs. The proposed rule indicates that new lists of APMs will be published annually, which makes timely review from PTAC and CMS extremely important to encourage participation in future program years. We appreciate that MACRA provides CMS with the ultimate decision-making authority for what qualifies as an APM, but PTAC can better facilitate multi-specialty APMs by providing CMS with an adequate number of proposals for consideration.

We would like CMS to clarify that it is not limited to considering PFPMs only on the timeline and recommendation of the PTAC. While the PTAC will be an important function in assessing many

PFPM proposals, the fact that CMS has ultimate decision-making authority for what qualifies as an APM should mean that CMS also has flexibility to propose necessary specialty-related PFPMs.

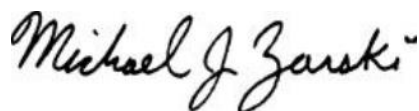
b. Supplemental Information Elements – Sec. II.F.10.d

CMS indicates in the proposed rule that it is weighing expedited consideration of recommended PFPMs when the proposal contains “supplemental information elements” not otherwise required by statute or regulation.

AAHKS Comment: If adopted, we urge that CMS or PTAC be required to provide formal guidance on what constitutes acceptable supplemental information and the precise manner in which supplemental information impacts a PFPM proposal. Additional information is certainly useful when considering any PFPM, but CMS runs the risk of creating a bifurcated system in which entities with the size and resources necessary to develop supplemental information are given priority over smaller proposals from entities that do not have the resources to conduct the optional studies.

AAHKS appreciates your consideration of our comments. You can reach me at mzarski@aaahks.org, or you may contact Joshua Kerr at jkerr@aaahks.org.

Sincerely,



Michael J. Zarski, JD
Executive Director
AAHKS